Beyond the Financial Terms: Understanding Key Legal Issues in Payer-Provider Contracts in 2018

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- Policies Procedures and Amendments (Does the Contract Say What I Think it Does?)
- All Products, Clauses, Rental, Leased, Limited and Tiered Networks and Assignments (What am I Signing Up For?)
- Billing, Payment and Utilization Review (When and How Do I Get Paid?)
- Services, Locations and After-Acquired Sites or Providers (To Whom Does the Contract Apply?)
- Dispute Resolution (How Do I Enforce the Contract?)
- Hospital Based Providers (Am I Responsible for Anyone Else?)
- Audits (How Do I Prove What I Think I Know?)
- Value Based Programs (Bells and Whistles No Longer?)

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Policies, Procedures and Amendments

- Many of the "operational" provisions of a managed care agreement are contained in a payer's policies and procedures (which may or may not be condensed by the payer into a provider manual), which are incorporated by reference into the agreement
  - Payers' desire, and to some extent need, flexibility to amend the policies and procedures BUT such changes can, in some cases, affect the economics of the arrangement

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Policies, Procedures and Amendments

- Most agreements will have a provision stating how the agreement can be amended
  - This provision does not necessarily apply to the changes to the payer's policies and procedures which often can be amended by the payer "from time to time."
- Since provider agreements can effectively be substantively changed in two ways, by amending the agreement or the payer's policies and procedures, advisors must be mindful of how both types of amendments can be made.

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Policies, Procedures and Amendments

- Types of Amendment Provisions:
  - Upon x number of days notice from payer:
    - Does the provider have the ability to terminate the agreement before the amendment goes into effect?
      - Termination is typically not optimal
    - Revenue neutrality protections (see below)
    - Objection period for provider
      - Consequences of objection:
        - » Amendment doesn't go into effect
        - » Provider terminates agreement
        - » Revenue neutrality protections kick in
      - Limit unilateral amendment to non-rate issues
        - » Non-rate changes can still decease reimbursement or increase cost

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Policies, Procedures and Amendments

- Revenue Neutrality Protections:
  - Cover revenue decrease and expense increase.
  - Does it apply to revenue decreases/expense increases of provider only or plan as well?
  - When protections are triggered?
    - Dollar one?
    - After a certain dollar threshold is hit
      - Material change
        - » Defined
        - » Material change under contract is arguably far less than a material change to a provider's revenue as a whole.

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Policies, Procedures and Amendments

- Does threshold have to be hit by a single change or by a group of changes over a period of time (e.g. one year)?

– What happens when threshold has been hit?

- Parties will negotiate revenue neutral rate increase to neutralize change.
- Lump sum payments to neutralize change.
- Binding third party decision maker if parties disagree?

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- All products clauses
  - Clauses that require provider to be in all “products” offered by the payer. (Definition of Product can vary)
    - HMOs (Including Point Service), PPOs
    - Commercial, Medicare Advantage
    - Self-Insured Payers where the “payer” is the administrator
      - The self-insured payer and not the contracting “payer”/administrator is typically solely responsible for payment.
      - Provider is generally required to participate in all self-insured payers’ plans.
        - » Exception: Payer doesn’t pay and provider opts out.
        - » Exception: Limited/Tiered Network constructed particularly for self-insured payer
          - » Hospital systems, universities

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- Leased and Rental Networks
  - Arrangements between the contracting “payer”/administrator and other payers that do not use the contracting “payer”/administrator as an administrator.
    - The other payer pays a fee to access the contracting “payer”/administrator’s network and contracted rates.
  - Opens up access to the contract to considerably more parties.
  - Concern in greater for provider under contracts with larger discounts.
  - If not allowed, all terms of the contract should apply to the lessee/payer, not just the rate.

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- Limited Networks v. Tiered Networks
  - Limited Networks are when only a portion of a payer's broad provider network is participating in a particular plan. All other providers, including those who are in the broad provider network are non-participating and are out of network for purposes of the plan.
  - Tiered networks typically include the payer's entire broad provider network as participating providers, but divide the network into tiers.
    - The preferred tier(s) has/have lower co-payments and sometimes lower deductible amounts applied to services rendered by providers in the "less-preferred" tier(s).

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- In order to be included in a narrow network or a more preferred tier, providers often provide rate reductions beyond the reductions they have agreed to in order to be included in the payer's broad network.
- Protections on Exclusions from Limited and Tiered Networks
  - Some contracts (particularly older legacy contracts) may require provider to be in limited networks and/or tiered products.
    - » Express steering or tiering prohibition
    - » Indirect language
      - » E.g., provider will participate in all payer plans and products
    - » If no such requirement exists, what other protections can be negotiated?

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- » Right of first offer/right of first refusal
  - » Timing requirements to exercise rights are critical
    - » Must account for plan cycles and regulatory notice requirements
    - » These vary by product (e.g., Medicare, Medicaid, Commercial)
  - » Rate increases on other business if excluded from a narrow or tiered network
- » Protections once in a limited or tiered network
  - » Exclusivity –
    - » Total – e.g., only hospital in top tier/narrow network
    - » Limited – e.g., provider's chief competitor(s) cannot be in top tier/narrow network

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- » Some protections can create tension with regulatory network adequacy requirements
- » Remedies for violation of protections
  - » Automatic rate increase for services rendered to tiered/narrow network enrollees or all payer enrollees
  - » Injunctive relief
  - » Exit tiered/narrow network

– Agreements are typically not assignable by providers, but many payer form agreements are assignable in whole or in part without the provider's consent

- Unfettered right to assign by payer can lead to access to the contract by leased and rental networks, acquirors and acquirees.

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All Product Clauses, Rental, Leased, Limited and Tiered Networks and Assignments

- In the era of payer mergers, the unfettered right to assign by payer can lead to two agreements with the same payer
  - E.g., Provider has a contract with Payers A and B., and A buys B. Depending on how the purchase is structured, the providers may end up with two contracts with A
- A change of control transaction (i.e., Payer A buys all stock of Payer B) is typically not covered by a garden variety anti-assignment provision and should be specifically addressed.
- If “affiliates” have rights to access contracts, an assignment may not be needed for an acquired payor to access the acquirers contracts or vice versa.

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Billing, Payment and Utilization Review

- Timing
  - State law typically requires that clean claims be paid within 30-45 days
    - Clean claim definition will ideally track state law
    - Clean claim payment and many other regulatory requirements (e.g., the requirement to pay interest if payment is late) should be restated in, or incorporated by reference into, contract.
      - A regulatory requirement alone may not provide a private right of action to the contracting party
  - Contract will typically limit the time from date of service in which a claim can be billed

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Billing, Payment and Utilization Review

- Often the provider contract will limit the time period in which a provider can challenge an underpayment to a period significantly less than the applicable statute of limitations, e.g., 18 months
  - Does the contract place the same time limit on the recovery of overpayments by the payer?

- Offsets/Take Backs
  - Can cause administrative and cash flow difficulties for providers.

Billing, Payment and Utilization Review

- Although arguably payers have a common law right to set off overpayments on past claims against current claims, some contracts will expressly grant the payer set-off rights.
  - Should at a minimum require notice and an opportunity to pay instead of being subject to offset.
- Current ERISA Issue: Can plan administrators offset a self-insured or a fully insured claim against a claim of another self-insured plan?

Billing, Payment and Utilization Review

- Groupers (inpatient claims)
  - Payers use groupers that are updated annually by CMS to group revenue and procedure codes on a submitted claim to determine a diagnosis related group (DRG) which will typically tie to a reimbursement rate
    - The contract should specify whether the grouper will update each year or stay stagnant through the contract term
      - Does the payer have the ability to determine which codes are grouped by the grouper or the order in which they are grouped through policy and procedures or otherwise?

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Billing, Payment and Utilization Review

- Emergency Services
  - Emergency services are typically subject to a more “lenient” prudent layperson under state or federal law (which should be restated and incorporated by reference into the contract) in order to qualify for payment than the “medical necessity” standard for non-emergency services and are not subject to preauthorization.
  - Admissions from the emergency room after the patient is stabilized are typically subject to the stricter medical necessity standard.
  - Payors are looking at “levels” of ER codes closely.

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Billing, Payment and Utilization Review

- Providers can consider contractual solutions to being “stuck” with a patient when the payer and physician disagree on medical necessity.
  - Require immediate transfer by payer to a lower level of care at payer’s expense.
    - » Appropriate where physician agrees that lower level of care is appropriate but unavailable.
  - Eliminate necessity of pre-approval for admissions coming out of the emergency room.
  - Consider an observation rate that accounts for the fact it will cover patients who need more intensive services than your typical observation patient.
  - Consider “placement” rate.

Billing, Payment and Utilization Review

- Utilization Review
  - Remember: patient is held harmless
    - Failure to get precert, can be fatal to a claim to be reimbursed for the service at all.
      - Exception: Patient expressly agrees to pay for the service prior to the service being rendered. General financial responsibility form will usually NOT suffice.
  - Once a service is pre-certified or otherwise approved as medically necessary that determination should not be changed absent fraud or misrepresentation by the provider

Services, Locations and After-Acquired Sites or Providers

- Contract language varies among payers regarding which services and locations are covered by the agreement
  - Some limit sites and entities covered very specifically (sometimes down to the floor or suite of a building) and any additional sites or entities can only be added with both parties' consent.
    - When so limited the contract should specify the status of those services that are not under contract.

Services, Locations and After-Acquired Sites or Providers

  - Do the hold harmless/non-covered services provisions apply?
  - Is the out-of-network payment under the plan payment in full?
- Such limitations must be kept in mind when acquiring new providers or establishing new sites.

– The scope of services covered is typically dictated by the rates set forth in the contract.

- "Catch-all" rate provisions are often used to cover all services that are not assigned specific rates.

– When services/sites are not expressly limited, assume all are subject to applicable rates.

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Dispute Resolution Under the Contract

- Arbitration or Litigation?
  - Depends on venue, preference of client, counsel.
  - Arbitration can be costly as the arbitrator(s) need to be paid for by the parties
    - Are three arbitrators necessary for all disputes?
  - Scheduling and rules tend to be more flexible in arbitration
    - Discovery in arbitration can be limited.
  - Arbitration may be final (subject to no or very limited appeals).

Dispute Resolution Under the Contract

– Arbitration clauses should be closely scrutinized and understood in connection with the rules and service under which the arbitration will be conducted.
  - AHLA
  - American Arbitration Association

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Dispute Resolution Under the Contract

- Site of arbitration or litigation is typically specified and can be critical.
  - Some venues more favorable than others depending on the party.
  - Convenience for parties and witnesses is a factor.
- What avenues must or can be exhausted before initiating litigation or arbitration? This will typically not be in the contract itself.
  - Internal appeals

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Dispute Resolution Under the Contract

- How many levels?
  - Timeframes for exercising appeal rights
- Are real time clinician to clinician “appeals” available.

– External Independent third party appeal (typically in um situations)
- Cost is a concern

– Is non-binding mediation required by the contract?

– Note: Some states like New Jersey have a regulatory mandated appeal system for some types (e.g., Non ERISA) of plans

- Some payers insist on no class or collective action clauses.

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Dispute Resolution Under the Contract

- Consider an external, final binding form of dispute resolution that is less adversarial and costly for lower disputed dollar amounts that cover groups of claims with common issues

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Hospital Based Providers (For Hospital Contracts)

- Insurers and legislators are becoming increasingly concerned with “surprise billings” by hospital based physicians who are not employed by the hospital and don’t participate with the enrollees’ payer.
- This subjects the patient, and in some cases the payor, to large “balance billing” financial obligations to providers who the enrollee didn’t choose and who have not agreed to accept a discounted rate from the payer as payment in full.

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Hospital Based Providers (For Hospital Contracts)

- Legislation is being discussed in New Jersey and Pennsylvania to attempt to address the situation.
  - Some hospital contracts impose some degree of responsibility for the hospital to require hospital based providers to participate and some financial consequences on the hospital if those providers don't participate with the payer.

Audits

- Unilateral or Mutual?
  - Payers often have detailed requirements for provider audits
    - Limitation on the number of audits/year
    - Limit on third party auditors
      - No contingent fees
      - No other audits of same payer for other party
      - Limitation to on-site audits
      - Limit on documentation that can be removed from site

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Audits

- Electronic v. Physical
  - Payers are accessing systems and/or requesting records electronically more often but on-site audits are still done (particularly for clinical records).
  - Reasonable notice should always be required, particularly for on-site visits.
  - Copying fees are often specified where copying is required, particularly for non-routine audits.

Value Based Programs

- Negotiated as addendums in addition to fee-for-service contracts/rates (i.e., they “sit” on top of FFS contracts)
- Can include quality and, for larger physician groups or hospital systems, cost components
- Cost-component is typically based on the fee-for service population assigned to primary care providers by either the selection of a primary care provider by the member in an HMO setting or by an attribution model based on encounters with a primary care provider throughout the year in a PPO setting.

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